TennCare HIPAA FAQs

10/31/2003

This document contains responses to TennCare HIPAA related frequently asked questions.

1. Does TennCare have a HIPAA webpage?
   a. Yes, TennCare maintains a HIPAA webpage at http://www.state.tn.us/tenncare/HIPAA/HIPAA%20Home.htm . TennCare's Companion Guide contains instructions for using the guides provided for each transaction, the Trading Partner Agreement, testing, and contact instructions are also on this page.

2. Where are the CMS FAQ's located?
   a. http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php

3. I am a software vendor that provides services for providers in Tennessee. Who do I need to test with?
   a. If the providers are LTC or SNF, then testing is done with TennCare. Refer them to the TennCare website for additional instructions. http://www.state.tn.us/tenncare/HIPAA/HIPAA%20Home.htm
   b. Otherwise, Tennessee is a managed care state and testing needs to be done with the appropriate Managed Care Contractor(s). A list of MCC contacts can be provided upon request. The source document is maintained on the TennCare HIPAA drive at H:\HIPPA\MCC External HIPAA Testing Contact List.doc

4. Is TennCare testing the claims transactions?
   a. TennCare is currently testing 837I version 4010A1 transactions with LTC, SNF, and waiver (HCBS) providers. The LTC TAD is being replaced with a web portal that generates compliant transactions.
   b. TennCare is testing the 837D, 837I, and 837P version 4010A1 encounter transactions with its Managed Care Contractors.
   c. TennCare is testing the 837I and 837P COB cross-over claims with the Medicare intermediaries.
   d. TennCare receives 837P claims only from the Department of Children's Services.

5. Is a contact list for the MCCs available?
   a. Yes. Note: The list is maintained on the HIPAA drive and will have to be emailed of faxed.

6. Who needs to complete a TPA with TennCare?
   a. Any provider, billing service or clearinghouse that transmits claims directly to TennCare must have a Trading Partner Agreement (TPA). The TPA is available on the TennCare website.
   b. Providers that submit claims to TennCare's Managed Care Contractors (MCCs) may need a TPA with the MCC.
   c. Providers that submit claims via the web portal will have to sign an agreement with the portal vendor.

7. Who do I need to test with?

a. A provider needs to test with every entity to which they submit claims.

8. What do I do with the completed TPA?
   a. Two original copies of a completed TPA must be mailed to TennCare at the following address:
      TennCare HIPAA Project Manager
      Bureau of TennCare
      729 Church Street
      Nashville, TN 37203

9. Do you know if Tennessee is going to be using the 837I format for both ICF (Level 1) and Skilled (Level 2) residents?
   a. The 837I may be used for all facilities along with UB92 paper claims and the web portal. This includes both ICF and skilled facilities.

10. Which 837 format will TennCare require for Home Health claims?
    a. Home Health providers may be associated with an institutional or professional claims processor. Therefore, TennCare currently accepts and will continue to accept and process home health services in both formats – the 837I and 837P.

11. Does the state intend to require ICFs that currently only do paper claims to submit electronically?
    a. No, any provider may continue to submit only standard paper claims as long as they meet the size requirements for a small provider as outlined by CMS and as long as they do all of their business in a manual manner.

12. Is there a Medicare requirement for ICFs to discontinue submitting paper claims and to begin submitting only electronic claims in October?
    a. Medicare requirements limit paper usage after October 16, 2003. The CMS website for FAQs may be accessed for additional details. http://www.cms.hhs.gov/hipaa/

13. What are TennCare's plans for claims received after October 16, 2003?
    a. TennCare's plan is to migrate to our new HIPAA compliant system as soon as possible. However, to ensure a smooth transition with adequate testing at all levels, TennCare will continue to run its existing system until testing is complete.
    b. To assure HIPAA compliance, TennCare has executed its contingency plan which will process any HIPAA compliant transactions submitted to TennCare. Please, contact TennCare to arrange testing before claims submissions.
    c. TennCare will continue parallel testing of the 837 encounter transactions with the MCCs and will expect MCC inbound encounter transactions to be HIPAA complaint after testing is completed.
    d. Claims from providers that have not completed testing will be allowed to continue in their existing format for the months of October and November.
    e. Additional announcements in this area may be made based upon testing activities.

14. Can vendors without TennCare providers test with TennCare to become certified vendors?

a. TennCare currently does not test with or certify vendors that do not service TennCare providers.

15. Does TennCare allow real time 270/271 eligibility inquiry into their system?
    a. TennCare currently has contracts that will remain effective after HIPAA implementation that allow web access with selected vendors. These vendors include WebMD, Medifax, Passport, and NIC (TennesseeAnytime).

16. How do you create an 837 void claim?
    a. A simple way to do a void is duplicate the original claim data, change CLM05:3 to an 8, change CLM01 to be the ICN of the void, and add REF01 = F8 with REF02 = original ICN.
    b. TennCare would also like to see the header paid AMT02 value set to 0 and a 2320 CAS segment added. The header level paid AMT segment is identified by AMT01 = D on the 837P/D or AMT01 = C4 on the 837I.
    c. The 2320 CAS segment should contain a valid CAS01 value with CAS02 not equal to 107 or 24 and CAS03 = original total paid amount (amount to be voided). An alternate method is to void every line with a 2430 CAS segment. At every line level, CAS01 must contain a valid value with CAS02 not equal to 107 or 24 with CAS03 = original paid amount (original SVD02 amount) and SVD02 changed to 0.
    d. Voids are easier to code at the claim header level than at the detail level.

17. Which frequency codes (CLM05:3) are expected by TennCare?
    a. TennCare expects to see all allowable codes on 837I claims and encounters.
    b. TennCare only expects to see 1, 7, and 8 on 837P and 837D claims and encounters.

18. What do the expected frequency codes (1, 7, 8) imply to TennCare?
    a. A 1 is used to identify an original claim/encounter.
    b. An 8 is used to identify a void.
    c. A 7 is used for a replacement claim/encounter. This code implies the indicated prior transaction is voided and that it is to be replaced with the information contained in the current transaction.
    d. A replacement claim is equivalent to submitting a void and a new original claim.

Encounter Related Questions

19. What is a TennCare encounter claim?
    a. All of TennCare's MCC submit encounters to TennCare. TennCare defines an encounter as a post-adjudicated claim.
    b. In an X12 format, a TennCare encounter looks very much like a COB claim being submitted from one insurance company to another.
    c. TennCare requires certain fields on all encounters.
        i. Claim level - receipt date, MCC ID, MCC ICN
        ii. Claim header level – allowed amt, billed amt, paid amt, CAS adjustment reason codes

iii. Claim detail level – allowed amt, billed amt, paid amt, CAS adjustment reason codes.

d. An encounter must be fiscally balanced. For example, the CLM02 value must be equal to the sum of all of the detail billed amounts plus any header level charges.

20. Where are the amount fields required on a TennCare encounter located within the 837?
    a. The MCC billed, allowed, and paid amounts are required on all TennCare 837 encounters.
    b. Encounter amounts may be provided in summary at the 2300 claim header level or provided on detail lines at the 2400 level. *Detail level information is preferred*.
    c. Allowed amt – at the header level allowed amt is in AMT02 where AMT01 = B6. The detail level allowed amt is in 2400 AMT02 where AMT01 = AAE on the 837P and 837D, on the 837I the detail level allowed amt is calculated by subtracting 2400 SV207 from 2400 SV203 (billed amt – non-covered amt).
    d. Paid amt – at the header level is in 2320 AMT02 where AMT01 = D for the 837P and 837D or AMT01 = C4 for the 837I. The detail level paid amt is at 2430 SVD02.
    e. Billed amt – At the header level is in CLM02. For an 837I this amount may also be placed in AMT02 where AMT01 = T3. At the detail level the billed amt is 2400 SV102 in the 837P, 2400 SV203 in the 837I, and 2400 SV302 in the 837D.
    f. Generally, header level fields must equal the summary of all detailed level fields.

21. How is a denial indicated on an encounter?
    a. An entire encounter claim may be denied by placing a 107 in a CAS adjustment reason code at the 2320 level. Doing this implies that all detail lines are also denied.
    b. An encounter line item(s) may be denied by placing a 107 in a CAS adjustment reason code at the 2430 level.
    c. The allowed and paid amounts on all denied services are 0.
    d. The adjustment reason codes on the provider 835 should be reflected in the 837.

22. How is a capitated service indicated on an encounter?
    a. An encounter line item(s) may be capitated by placing a 24 in a CAS adjustment reason code at the 2430 level.
    b. An entire encounter claim may be capitated by placing a 24 in a CAS adjustment reason code at the 2320 level.
        i. Doing this implies that all detail lines are also capitated unless a detail level override adjustment reason code is provided in a 2430 CAS segment.
        ii. On an 837P or 837D, if a line item(s) within a capitated encounter is to be paid as a fee-for-service line then the adjustment reason code of A2 (contractual adjustment) but be used in that line item's 2430 level CAS segment.
        iii. An 837I encounter cannot be partially capitated. An 837I encounter can only be capitated in its entirety. This must be done at the header level with a 2320 CAS value of 24.
    c. The allowed amounts on a capitated service should reflect the allowed amount as if the service was being paid under a fee-for-service agreement.

d. All capitated services must have a paid amount of 0.

23. Are zero dollar amounts valid on an encounter?
    a. Zero dollar amounts are valid for the billed, allowed, and paid amounts of an encounter claim. Business rules should be applied so that valid, auditable decisions are made.

24. How is TPL reported on an 837 encounter?
    a. A TennCare encounter is setup to mirror TPL (COB) reporting activities using the 2320 segment and the associated 2330B and 2430 loops. TennCare encounter reporting should use the first set of 2320 loops. A TennCare encounter is a COB claim.
    b. TPL is reported using additional 2320 and the associated 2330B and 2430 loops.

25. What CAS adjustment reason codes have special meaning to TennCare?
    a. 1 = Deductible Amount
    b. 2 = Coinsurance Amount
    c. 3 = Co-payment Amount
    d. 24 = Capitated service
    e. 66 = FFS blood deductible
    f. 107 = Denied service
    g. A2 = Contractual adjustment used to indicate payment of a FFS line on a capitated encounter.
    h. All adjustment reason codes are valid on encounters or FFS claims.
    i. The adjustment reason codes on the provider 835 should be reflected in the 837.